STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175340	A. BUILDING _____ B. WING _____	C 12/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALDERSGATE VILLAGE	3220 SW ALBRIGHT DR TOPEKA, KS 66614

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #73647, 75580, 75852, 77422, and 78789	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: The facility identified a census of 180 residents with 38 residents on the Eastminister unit. Based on observation, interview, and record review, the facility failed to promote the dignity of six unsampled dependent residents in the dining process of the Eastminister unit. Findings included: - A mealtime sign posted on the wall next to the kitchenette service window on Eastminister unit recorded breakfast at 8:00 A.M., lunch at 12:00 noon, and supper 6:00 P.M. Observation of breakfast on the Eastminister unit on 12/2/14 from 8:25 A.M. to 9:05 A.M. revealed three residents sat in wheelchairs and Broda chairs (specialized wheelchair with the ability to tilt and recline) at a table in the back of the Eastminister dining room without food or beverage as dietary staff DD obtained breakfast orders and served the other residents in the dining room. At 8:35 A.M., direct care staff M and N delivered room trays to five residents on the unit halls.	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 241	Continued From page 1 At 8:48 A.M., thirteen residents remained in the dining room with 10 residents waiting on service, and direct care staff Q assisted one resident at another table of three residents, as the other two residents sat without food or beverage. At 8:55 A.M., six residents remained seated without food or beverage. At 9:05 A.M., staff served food and beverage to the remaining dependent five unsampled dependent residents at the back of the dining room and direct care staff sat and assisted the residents. Observation of the noon meal on the Eastminister unit on 12/2/14 from 12:05 P.M. revealed 24 residents in the dining room. A table of 3 unsampled dependent residents in the back of the dining room revealed one resident with food and beverage and assisted by direct care staff Q with eating. The other two unsampled residents sat without food, beverage, or assistance until 12:20 P.M. when dietary staff DD delivered the food service and direct care staff sat to assist the residents. At 12:10 P.M., a second table of 4 unsampled residents revealed staff assisted one unsampled resident while 3 other dependent residents sat at this table without food or beverage. Between 12:20 P.M. and 12:24 P.M., staff delivered two more residents the noon meal and beverages and staff assisted these 2 residents with the meals. A fourth unsampled resident remained without food or beverage during this time. At 12:25 P.M. dietary staff DD served the fourth unsampled resident beverages and no food. The unsampled resident continued to wait for food service as staff assisted the other residents at the table with the noon meal.	F 241		

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F 241	Continued From page 2 During an interview on 12/2/14 at 12:35 P.M. dietary staff CC reported the resident had not been serviced because the kitchenette ran out of mechanical soft meals and had to order more from the main kitchen. On 12/2/14 at 12:36 P.M. consultant dietary staff GG reported the kitchen knew how many altered texture diets to make, but did not make enough. It was the kitchen chef and cooks responsibility to send the right number of meals to each unit. Consultant dietary staff GG and dietary staff CC reviewed the dietary list and reported 5 residents received pureed diet, 8 residents received a full mechanical soft diet, and 2 residents received mechanical ground meat with the meals. An interview with dietary staff FF on 12/2/14 at 1:35 P.M., revealed the dietary staff referred to the posted dry-erase wallboard for the number of pureed diets. The wallboard recorded 4 pureed diets for Eastminister. Dietary staff FF reported the all-facility paper copy of the dietary lists was updated each month; however, he/she was unable to find the list at this time. On 12/2/14 at 1:36 P.M. consultant dietary staff EE revealed the all-facility paper copy of dietary lists taped above the food preparation table, dated 10/17/14. Review of the posted all-facility paper copy of the dietary list recorded 5 pureed meals and 10 mechanical ground soft meals for the residents on Eastminister. Consultant dietary staff EE reported sometimes the kitchen falls short on prep, have to get food from another neighborhood, and confirmed the dry-erase board was not accurate.	F 241		

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F 241	Continued From page 3 On 12/2/14 at 8:40 A.M., direct care staff Q reported the nursing staff delivered the room trays before assisting residents with meals in the dining room. On 12/2/14 at 2:18 P.M. direct care staff M reported the when all the residents that ate independently were in the dining room, direct care staff served room trays to residents. After staff finished room tray pass they assisted the dependent residents in the dining room with eating. The facility policy Resident Meal Service dated 9/2013, recorded staff served meals in a manner that enhanced each resident ' s dignity. When service style was more traditional service (with fixed dining times), the staff served meals in sequence so that all persons at one table were served at the same time. The facility failed to provide a dining service that promoted dignity for residents in the unit.	F 241		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility identified a census of 180 residents with 38 residents on the Eastminister neighborhood. The facility failed to ensure	F 323		

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F 323	Continued From page 4	F 323		

supervision and a safe environment for two cognitively impaired independently mobile residents, which resided on the Eastminister neighborhood.

Findings included:

- Observation on 12/2/14 at 1:10 P.M. revealed dietary staff CC exited the kitchenette on the Eastminister neighborhood into the main hallway and left this kitchenette door propped open.

The sign placed on the door documented, keep door closed when not in use. Notice: only authorized persons allowed in Galley kitchen.

Observation on 12/2/14 from 1:10 P.M. to 1:30 P.M. revealed the kitchenette door into the main hallway remained open and the following:
The operating dishwasher revealed an electronic panel that recorded a wash water temperature of 164 to 171 degrees Fahrenheit and a rinse water temperature of 179 degrees Fahrenheit.
The steam table presented with covered five water reservoirs with water temperatures in Fahrenheit of 142.8, 151.7, 147.8, 124, and 103.3 degrees.

On 12/2/14 at 1:30 P.M. dietary staff CC returned to the kitchenette through the open door, out into the dining room and left the hallway entrance door open.

On 12/2/14 at 1:31 P.M., dietary staff CC revealed staff should keep the door to the kitchenette closed.

The facility failed to ensure the supervision and safety to prevent burns from hot water for two cognitively impaired independently mobile

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F 323	Continued From page 5 residents on this unit.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This Requirement is not met as evidenced by: The facility identified a census of 180 residents with 38 residents on the Eastminister unit. Based on observation, interview, and record review the facility failed to ensure the safe food storage in the kitchenette for the Eastminister unit. Findings included: - Observation on 12/2/14 at 8:25 A.M., revealed a rolling cart that held four 2-quart containers of lemonade, cranberry, orange, and apple juices with an orange label which recorded an open date of 11/29/14 and use-by date (expiration) of 11/30/14. Continued observation of the meal service through 9:00 A.M. revealed dietary staff DD served the residents in the dining room the juice from these containers. Observation on 12/2/14 at 8:35 A.M. revealed direct care staff M and N prepared glasses of juice for resident room trays from the containers of expired juices. An interview with dietary staff CC on 12/2/14 at	F 371		

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F 371	Continued From page 6 8:45 A.M., revealed staff reviewed the labels when setting out the food and juices and confirmed the four containers of juice were expired. Observation on 12/2/14 at 8:48 A.M. revealed the large commercial refrigerator in the dining room contained four unlabeled and undated pureed meals with green and tan formed patties on divided plates covered with plastic wrap. On 12/2/14 at 8:50 A.M. dietary staff CC reported the unlabeled pureed meals in the refrigerator were for resident lunches. An interview with consultant dietary staff EE on 12/2/14 at 9:00 A.M. revealed the unlabeled, undated pureed meals stored in the refrigerator were for resident lunches today. Consultant dietary staff EE revealed he/she was unaware the meals made today required labels. Consultant dietary staff EE confirmed the juice beverages on the rolling cart were expired. On 12/2/14 at 1:10 P.M., a poster in the kitchenette recorded all open food items must have an orange label with the date, product name, time, expiration date, and staff initials. Open items without labels were thrown away. The facility provided policy for Food and Supply Storage Procedures dated 1/2014 recorded the " use-by " date was the last date that a food could be consumed; do not place on patient trays/resident plates past the date on the product. Foods past the " use-by " date were discarded. Cover, label, and date unused portions of open packages. Use and complete all sections on the Morrison orange label.	F 371		

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F 371	Continued From page 7 The facility failed to store, prepare, and serve food in a sanitary manner for the 38 residents in this unit.	F 371		